

This page to be completed by:  
Program Staff and Parent or Guardian

## Diabetes Care Plan Request Form

Child's name: \_\_\_\_\_

Child's date of birth: \_\_\_\_\_

Early Learning or Child Care Program Director: \_\_\_\_\_

Early Learning or Child Care Program: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_

**Healthcare Provider:** The child listed above attends our program. This packet includes forms to help meet our licensing standards for medications and individual care plans. **Please complete pages 2-5.** These are forms that require a healthcare provider's instructions and signature.

By signing below, I give permission to my child's healthcare provider to release the health information requested in the following care plan to my child's program.

Parent or Guardian Name (Printed): \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent or Guardian Phone Number: \_\_\_\_\_

# Childcare Diabetes Medical Management Plan

CHILD'S LAST NAME:

FIRST NAME:

DOB:

**PARENTS/GUARDIANS: If child is independent or partially independent, use School DMMP.****1. DEMOGRAPHIC INFORMATION — PARENT/GUARDIAN TO COMPLETE**

Child's First Name:	Last Name:	DOB:	Child's Cell #:	Diabetes Type:	Date Diagnosed: Month:      Year:
Childcare Center Name and Address:					Phone #:
Child Care Center Point of Contact:					Contact Phone #:

<b>CHILD'S SCHEDULE</b>	Arrival Time:	Dismissal Time:
Meals Times:	Time/Carbohydrate Amount:	Physical Activity :      Time of Day/Duration:
Breakfast		Playground
AM Snack		Active Games
Lunch		Sports
PM Snack		Additional information:
Pre Dismissal Snack		
Other		

Parent/Guardian #1 (contact first):	Relationship:	Parent/Guardian #2:	Relationship:
Cell #:	Home #:	Work #:	Cell #:      Home #:      Work #:
E-mail Address:	E-mail Address:		
Indicate preferred contact method:	Indicate preferred contact method:		

**2. RECOGNITION OF HIGH OR LOW GLUCOSE SYMPTOMS (CHECK ALL THAT APPLY)****Symptoms of High:**

Thirsty    Frequent Urination    Fatigued/Tired/Drowsy    Headache    Blurred Vision    Warm/Dry/Flushed Skin  
 Abdominal Discomfort    Nausea/Vomiting    Fruity Breath    Incontinence    Temper Tantrums    Behavior Changes    Unaware  
 Other:

**See Section 7 for treatment.****Symptoms of Low:**

None    Hungry    Shaky    Pale    Sweaty    Tired/Sleepy    Tearful/Crying    Dizzy Irritable  
 Unable to Concentrate    Confusion    Personality Changes    Other:

**See Section 6 for treatment.****Self-management skills:** Full Support    Supervision    Self-care**Allow child to:** Select finger for BG testing    Select injection site    Select food-snacks    Other:

Name of Health Care Provider/Clinic:

Contact #:

Fax #:

Email Address (non-essential communication):

Other:

### 3. GLUCOSE MONITORING

#### Monitor Glucose:

Before Meals    With Physical Complaints/Illness (include ketone testing)    High or Low Glucose Symptoms  
Before Nap    After Nap    Before Physical Activity    After Physical Activity    Before Leaving School    Other:

#### CONTINUOUS GLUCOSE MONITORING (CGM)

(Specify Brand & Model:

Specify Viewing Equipment:    Device Reader    Smart Phone  
Insulin Pump    Smart Watch    iPod/iPad/Tablet

CGM is remotely monitored by parent/guardian.

May use CGM for monitoring/treatment/insulin dosing unless symptoms do not match reading.

#### CGM Alarms:

Low alarm                      mg/dL

High alarm                      mg/dL if applicable

#### Please:

- Permit access to center Wi-Fi for sensor data collection and data sharing
- Do not discard transmitter if sensor falls

#### Perform finger stick if:

- Glucose reading is below                      mg/dL or above                      mg/dL
- If CGM is still reading below                      mg/dL (DEFAULT 70 mg/dL) 15 minutes following low treatment
- CGM sensor is dislodged or sensor reading is unavailable.
- Sensor readings are inconsistent or in the presence of alerts/alarms
- Dexcom does not have both a number and arrow present
- Libre displays Check Blood Glucose Symbol
- Using Medtronic system with Guardian sensor

#### Notify parent/guardian if glucose is:

below                      mg/dL (<55 mg/dL DEFAULT)

above                      mg/dL (>300 mg/dL DEFAULT)

**Section 1-3 completed by Parent/Guardian**

### 4. INSULIN DOSES AT CENTER - HEALTHCARE PROVIDER TO COMPLETE

#### Insulin Administered Via:

Syringe    Insulin Pen (    Whole Units    Half Units)  
i-Port    Smart Pen  
Other

Insulin Pump (Specify Brand & Model:                      )  
Insulin Pump is using Automated Insulin Delivery (automatic dosing) using an FDA-approved device  
Insulin Pump is using DIY Looping Technology (child/parent manages device independently, staff will assist with all other diabetes management)

**DOSING** to be determined by Bolus Calculator in insulin pump or smart pen/meter unless moderate or large ketones are present or in the event of device failure (provide insulin via injection using dosing table in section 4A).

#### Insulin Administration Guidelines

Insulin Delivery Timing: Pre-meal insulin delivery is important in maintaining good glucose control. Late or partial doses are used with children that demonstrate unpredictable eating patterns or refuse food. Provide substitution carbohydrates when child does not complete their meal.

**Prior to Meal** (DEFAULT)

**After Meal** as soon as possible and within 30 minutes

**Snacking** avoid snacking                      hours (DEFAULT 2 hours) before and after meals

#### Partial Dose Prior to Meal: (preferred for unpredictable eating patterns using insulin pump therapy)

Calculate meal dose using                      grams of carbohydrate prior to the meal

Follow meal with remainder of grams of carbohydrates (may not be necessary with advanced hybrid pump therapy)

May advance to Prior to Meal when child demonstrates consistent eating patterns.

#### For Injections, Calculate Insulin Dose To The Nearest:

Half Unit (round down for < 0.25 or < 0.75 and round up for ≥ 0.25 or ≥ 0.75)

Whole Unit (round down for < 0.5 and round up for ≥ 0.5)

#### Preferred injection site:

#### Additional Insulin Orders:

Check for **KETONES** if child complains of physical symptoms such as nausea, vomiting, fever, or stomachache. Refer to section 7. for high blood glucose management information.

Parents/guardians are authorized to adjust insulin dose +/-                      units

**4A. DOSING TABLE – HEALTHCARE PROVIDER TO COMPLETE – SINGLE PAGE UPDATE ORDER FORM**

**Insulin:** (administered for food and/or correction)

**Rapid Acting Insulin:** Humalog/Admelog (Lispro), Novolog (Aspart), Apidra (Glulisine) Other:

**Ultra Rapid Acting Insulin:** Fiasp (Aspart) Lyumjev (Lispro-aabc) Other:

**Other insulin:** Humulin R Novolin R

Meal & Times	Food Dose		Glucose Correction Dose Use Formula      See Sliding Scale 6B		PE/Activity Day Dose	
	Select if dosing is required for meal	<b>Carbohydrate Ratio:</b> Total Grams of Carbohydrate divided by Carbohydrate Ratio = Carbohydrate Dose	<b>Fixed Meal Dose</b>	<b>Formula:</b> (Pre-Meal Glucose Reading minus <b>Target Glucose</b> ) divided by <b>Correction Factor</b> = Correction Dose May give Correction dose every _____ hours as needed (DEFAULT 3 hours)		<b>Adjust:</b> <b>Carbohydrate Dose Total Dose</b> Indicate dose instructions below:
<b>Breakfast</b>	Breakfast Carb Ratio = _____ g/unit	<b>Breakfast</b> units	<b>Target Glucose is:</b> _____ mg/dL & <b>Correction Factor is:</b> _____ mg/dL/unit <hr/> <b>No Correction dose</b>		Carb Ratio	g/unit
					Subtract	%
					Subtract	units
<b>AM Snack</b>	AM Snack Carb Ratio = _____ g/unit	<b>AM Snack</b> units	<b>Target Glucose is:</b> _____ mg/dL & <b>Correction Factor is:</b> _____ mg/dL/unit <hr/> <b>No Correction dose</b>		Carb Ratio	g/unit
	No Carb Dose      No Insulin if < _____ grams				Subtract	%
					Subtract	units
<b>Lunch</b>	Lunch Carb Ratio = _____ g/unit	<b>Lunch</b> units	<b>Target Glucose is:</b> _____ mg/dL & <b>Correction Factor is:</b> _____ mg/dL/unit <hr/> <b>No Correction dose</b>		Carb Ratio	g/unit
					Subtract	%
					Subtract	units
<b>PM Snack</b>	PM Snack Carb Ratio = _____ g/unit	<b>PM Snack</b> units	<b>Target Glucose is:</b> _____ mg/dL & <b>Correction Factor is:</b> _____ mg/dL/unit <hr/> <b>No Correction dose</b>		Carb Ratio	g/unit
	No Carb Dose      No Insulin if < _____ grams				Subtract	%
					Subtract	units
<b>Dinner</b>	Dinner Carb Ratio = _____ g/unit	<b>Dinner</b> units	<b>Target Glucose is:</b> _____ mg/dL & <b>Correction Factor is:</b> _____ mg/dL/unit <hr/> <b>No Correction dose</b>		Carb Ratio	g/unit
					Subtract	%
					Subtract	units

**4B. CORRECTION SLIDING SCALE**

Meals Only	Meals and Snacks	Every	hours as needed
to _____ mg/dL = _____ units	to _____ mg/dL = _____ units	to _____ mg/dL = _____ units	to _____ mg/dL = _____ units
to _____ mg/dL = _____ units	to _____ mg/dL = _____ units	to _____ mg/dL = _____ units	to _____ mg/dL = _____ units
to _____ mg/dL = _____ units	to _____ mg/dL = _____ units	to _____ mg/dL = _____ units	to _____ mg/dL = _____ units

**4C. LONG ACTING INSULIN**

Time	Lantus, Basaglar, Toujeo (Glargine) Levemir (Detemir) Tresiba (Degludec) Other	units	Daily Dose	Subcutaneously
------	---	-------	------------	----------------

**4D. OTHER MEDICATIONS**

Time	Other	units	Daily Dose	Route
------	-------	-------	------------	-------

Signature is required here if sending  
ONLY this one-page dosing update.

**Diabetes Provider Signature:**

**Date:**

## 5. LOW GLUCOSE PREVENTION (HYPOGLYCEMIA)

### Allow Early Interventions

Give Mini-Dosing of carbohydrate (i.e., 1-2 glucose tablets; glucose gel to infants) when low glucose is predicted, sensor readings are dropping (down arrow) at \_\_\_\_\_ mg/dL (DEFAULT 80 mg/dL or 120 mg/dL prior to physical activity) or with symptoms.

Allow child to carry and consume snacks \_\_\_\_\_ Childcare staff to administer

Allow Trained Staff/Parent/Guardian to adjust mini dosing and snacking amounts (DEFAULT)

### Insulin Management (Insulin Pumps)

**Temporary Basal Rate** Initiate pre-programmed rate as indicated below to avoid or treat hypoglycemia.

Pre-programmed Temporary Basal Rate Named \_\_\_\_\_ (Omnipod)

Temp Target (Medtronic) \_\_\_\_\_ Exercise Activity Setting (Tandem)

Activity Feature (Omnipod 5) \_\_\_\_\_ None available, disconnect from pump (iLet)

**Start:** \_\_\_\_\_ minutes prior to physical activity for \_\_\_\_\_ minutes duration (DEFAULT 1 hour prior, during, and 2 hours following physical activity).

**Initiated by:** Trained Staff \_\_\_\_\_ Nurse/health care provider

May disconnect and suspend insulin pump up to \_\_\_\_\_ minutes (DEFAULT 60 minutes) to avoid hypoglycemia, personal injury with certain physical activities or damage to the device (keep in a cool and clean location away from direct sunlight).

**Physical Activity is a very important part of diabetes management and should always be encouraged and facilitated).**

### Physical Activity Monitoring

\_\_\_\_\_ prior to physical activity \_\_\_\_\_ every 30 minutes during extended physical activity \_\_\_\_\_ following physical activity with symptoms

**Delay physical activity if glucose is < \_\_\_\_\_ mg/dL (120 mg/dL DEFAULT)**

### Pre-Physical Activity Routine

**Fixed Snack:** Provide \_\_\_\_\_ grams of carbohydrate prior to physical activity if glucose < \_\_\_\_\_ mg/dL

**Added Carbs:** If glucose is < \_\_\_\_\_ mg/dL (120 DEFAULT) give \_\_\_\_\_ grams of carbohydrates (15 DEFAULT)

**TEMPORARY BASAL RATE as indicated above**

**Encourage and provide access to water for hydration, carbohydrates to treat/prevent hypoglycemia, and bathroom privileges during physical activity**

## 6. LOW GLUCOSE MANAGEMENT (HYPOGLYCEMIA)

Low Glucose below \_\_\_\_\_ mg/dL (below 70 mg/dL DEFAULT) or below \_\_\_\_\_ mg/dL before/during physical activity ( DEFAULT is < 120 mg/dl).

1. If child is awake and able to swallow give \_\_\_\_\_ grams of fast acting carbohydrate (DEFAULT 15 grams). Examples include 4 ounces of juice or regular soda, 4 glucose tabs, 1 small tube glucose gel.  
Parent may change amount given
2. Check blood glucose every 15 minutes and re-treat until glucose > \_\_\_\_\_ mg/dL (DEFAULT is 80 mg/dL or 120 mg/dL before physical activity).

### SEVERE LOW GLUCOSE (unconscious, seizure, or unable to swallow)

Administer Glucagon, position child on their side and monitor for vomiting, call 911 and notify parent/guardian. If BG meter is available, confirm hypoglycemia via BG fingerstick. Do not delay treatment if meter is not immediately available. If wearing an insulin pump, place pump in suspend/stop mode or disconnect tubing from infusion site. Keep pump with child.

Gvoke PFS (prefilled syringe) by SC Injection 0.5 mg 1.0 mg

Gvoke HypoPen (auto-injector) by SC Injection 0.5 mg 1.0 mg

Gvoke Kit (ready to use vial and syringe, 1mg/0.2 ml) by SC injection

Zegalogue (dasiglucagon) 0.6 mg SC by Auto-Injector Zegalogue (dasiglucagon) 0.6 mg SC by Pre-Filled Syringe

Baqsimi Nasal Glucagon 3 mg

## 7. HIGH GLUCOSE MANAGEMENT (HYPERGLYCEMIA)

Management of High Glucose over \_\_\_\_\_ mg/dL if within \_\_\_\_\_ hours of food intake. (Default is 300 mg/dL OR 250 mg/dl if on an insulin pump).

1. Provide and encourage consumption of water or sugar-free fluids. Give 4-8 ounces of water every 30 minutes. May consume fluids in classroom. Provide carbohydrate free snacks, if hungry. Allow frequent bathroom privileges.
2. Check for Ketones (before giving insulin correction)
  - a. If Trace or Small Urine Ketones (0.1 – 0.5 mmol/L if measured in blood)
    - Consider insulin correction dose. Refer to the “Correction Dose” Section 4.A-B. for designated times correction insulin may be given.
    - *Can remain at center*
    - Recheck glucose and ketones in 2 hours
  - b. If Moderate or Large Urine Ketones (0.6 – 1.4 mmol/L or >1.5 mmol/L blood ketones). This may be serious and requires action.
    - Contact parents/guardian or, if unavailable, healthcare provider
    - **Administer correction dose via injection.** If using Automated Insulin Delivery contact parent/provider about turning off automatic pump features. Refer to the “Blood Glucose Correction Dose” Section 4.A-B
    - **If using insulin pump, change infusion site/cartridge or use injections until dismissal.**
    - No physical activity until ketones have cleared
    - Report nausea, vomiting, and abdominal pain to parent/guardian to take child home.
    - Call 911 if changes in mental status and labored breathing are present and notify parents/guardians.

### SIGNATURES

**This Diabetes Medical Management Plan has been approved by:**

Child’s Physician/Health Care Provider:

Date:

I, (parent/guardian) \_\_\_\_\_ give permission to child care center owner, qualified health care professional or trained employees of (center name) \_\_\_\_\_ to perform and carry out the diabetes care tasks as outlined in this childcare Diabetes Medical Management Plan. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all center employees and other adults who have responsibility for my child and who may need to know this information to maintain my child’s health and safety. I also give permission to the child care center owner or qualified health care professional to collaborate with my child’s physician/health care provider.

**Acknowledged and received by:**

Child’s Parent/Guardian:

Date:

**Acknowledged and received by:**

Childcare Center Representative:

Date:

## 3-Day Critical Medication Authorization Form

**Healthcare Provider and Parent or Guardian:** In the event the child needs to remain at the program past usual hours, a 3-day supply of Critical Medication(s) must be kept at the program. This life-sustaining medication is usually given when the child is not in care. Examples may include certain diabetes, seizure, or asthma medications. A new 3-Day Critical Medication Authorization Form should be completed if there are changes to the medication or child's health condition.

**Program Staff:** This life-sustaining medication will only be given if the child needs to remain at the program past usual hours. Each 3-Day Critical Medication must have its own 3-Day Critical Medication Authorization Form. Never give an expired medication. An expired medication must be replaced, and the updated expiration date must be added to this form.

**Child's name:** \_\_\_\_\_

**Child's date of birth:** \_\_\_\_\_

**Name of medication:** \_\_\_\_\_

**Reason for medication:** \_\_\_\_\_

**Possible side effects of medication:** \_\_\_\_\_

**Medication expiration date:** \_\_\_\_\_

**When to give medication** (do not write 'as needed' or 'ongoing'; list symptoms or times of day to give the medication): \_\_\_\_\_

**How much medication to give** (must include dose of medication): \_\_\_\_\_

**How long to give medication** (do not write 'as long as needed' or 'ongoing'; write a date to stop giving medication, no longer than 1 year): \_\_\_\_\_

**How to give the medication** (for example: by mouth [oral], on skin [topical], injection, etc.): \_\_\_\_\_

This page to be completed by:  
Healthcare Provider and Parent or Guardian

## 3-Day Critical Medication Authorization Form (Continued)

**Medication requires special storage:** ☐ Yes ☐ No

**If yes, specify** (for example: refrigerate; keep away from light; etc.): \_\_\_\_\_

**Additional instructions:** \_\_\_\_\_

**Parent or Guardian:** By signing below, I give the program permission to give this medication to my child as described on this 3-Day Critical Medication Authorization Form.

**Parent or Guardian Name (Printed):** \_\_\_\_\_

**Parent or Guardian Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Healthcare Provider:** By signing below, I acknowledge that this child requires a 3-Day supply of critical medication to be stored at the child's program. **It will only be given in the event the child needs to remain at the program past usual hours.**

**Healthcare Provider Name (Printed):** \_\_\_\_\_

**Healthcare Provider Signature:** \_\_\_\_\_

**Healthcare Provider Phone Number:** \_\_\_\_\_

**Date:** \_\_\_\_\_



This page to be completed by:  
Program Staff and Parent or Guardian

## Additional Requirements for Care Plans

Child's name: \_\_\_\_\_

**Program Staff and Parent or Guardian:** The WAC requires that all care plans include the potential side effects and expiration date of medications. If this is not included in the care plan, write them in the table below. **You may find this information on the medication packaging or label.**

Medication Name	Expiration Date	Potential Side Effects

**Program Staff and Parent or Guardian:** The WAC requires a parent, guardian, or appointed designee to provide training to program staff about medication administration or special medical procedures listed in the child's care plan. **Use the space below to document this training.**

Employee Training Record				
Date of Training	Employee Name (Printed)	Employee Signature	Trainer Name (Printed)	Trainer Signature

**Program Staff and Parent or Guardian:** The WAC requires written consent from a child's parent or guardian before a program can administer any medications or follow a care plan that is completed by a healthcare provider. **Please have the parent or guardian sign below.**

By signing below, I give the program permission to follow this care plan as ordered by the healthcare provider.

Parent or Guardian Name (Printed): \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

This page to be completed by:  
Parent or Guardian

## Emergency Contact Information

Child's name: \_\_\_\_\_

**Parent or Guardian:** If your child has a medical emergency, program staff need to be able to contact you or another emergency contact as quickly as possible. Please complete the following:

### Emergency Contact #1

Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### Emergency Contact #2

Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### Emergency Contact #3

Name: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

Phone Number: \_\_\_\_\_

This page to be completed by:  
Program Staff

## Medication Log

**Program Staff:** Please print a Medication Log for each medication (including any 3-Day Critical Medication).

**Child's name:** \_\_\_\_\_

**Child's date of birth:** \_\_\_\_\_

**Name of medication:** \_\_\_\_\_

Date	Time	Dose	Person Giving Medication (*Initials)	Reason Medication Was Not Given	Observed Side Effects

Initials*	Printed Name and Signature of Person Giving Medications